Supreme Court, U.S.
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No. 99-1083

IN THE

Supreme Court of the United States

OCTOBER TERM, 1999

JEFFREY HULL,
Petitioner,

v.

RICHARD H. FALLON, M.D., ET AL.,
Respondents.

On Petition for a Writ of Certiorari to the
United States Court of Appeals for the Eighth Circuit

BRIEF OF RESPONDENTS RICHARD H. FALLON, M.D., AND THE PRUDENTIAL INSURANCE COMPANY OF AMERICA IN OPPOSITION TO PETITION FOR CERTIORARI

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CORPORATE DISCLOSURE

The Prudential Insurance Company of America is a mutual insurance company that has no publicly traded stock. It has no parent corporation or nonwholly-owned subsidiaries.

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RESPONDENTS' STATEMENT OF THE CASE[1]

Petitioner Jeffrey Hull ("Hull") was an employee of The Prudential Insurance Company of America ("Prudential") in 1996. As such, he had group health care coverage through a Plan issued by Prudential Health Care Plan, Inc. ("PruCare"). The Plan was a part of Prudential's employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§1001 *et seq.* ("ERISA"), and Hull was a "participant" in the Plan. Respondent Dr. Richard H. Fallon was a physician employed by Prudential as Medical Director for the Plan.

In January, 1996, Hull consulted Dr. Delcau, who is not employed by or otherwise connected with PruCare. Hull complained of chest pains and shortness of breath. Dr. Delcau considered the advisability of a thallium stress test, and he called Dr. Fallon to see if PruCare, through the Plan, would agree in advance to pay the costs of that procedure. Dr. Fallon refused on behalf of PruCare to agree to pay the costs of a thallium stress test for Hull. The Plan obligates payment only for those procedures that are "medically necessary," and Dr. Fallon did not believe that a thallium stress test was "medically necessary" within the meaning of the Plan.

Thereafter, in January 1998, Hull filed an action against Dr. Fallon, Prudential, and PruCare[2] in the Circuit Court for St. Louis County, Missouri. He alleged that Dr. Fallon's refusal to precertify benefits for a thallium stress test constituted medical malpractice, as a result of which he had suffered a myocardial

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[1] Hull's "Statement of the Case," Petition for Certiorari, page 3, does not set forth the facts in sufficient detail for the Court to identify with particularity the issues that would be before the Court if it grants certiorari.

[2] Hull also sued a whole array of entities that included the name "Prudential," but which had nothing to do with this case.

infarction and other medical conditions. He did not allege that he could not afford the thallium stress test if PruCare did not pay for it. Indeed, in an affidavit filed in support of his motion to remand he affirmatively stated that he could have afforded the test even if PruCare did not pay for it.

Respondents timely removed the case to the United States District Court for the Eastern District of Missouri on federal question grounds. Respondents asserted that they had done no more than to deny benefits under an employee welfare benefit plan, and that the district court therefore had subject matter jurisdiction under ERISA §502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B).

On Hull's motion to remand the district court considered affidavits submitted by both Hull and PruCare. The district court found that the evidence did not support Hull's contention that Dr. Fallon acted as a treating physician. "Dr. Fallon did not prescribe treatment for Hull, he merely identified what treatment would be paid for by Hull's benefit plan." (Petitioner's Appendix, p. 15a.) The district court denied Hull's motion to remand.

The district court also granted Prudential's motion to dismiss on the ground that Hull's substantive claims were preempted by ERISA §514(a), 29 U.S.C. §1144(a), and it gave Hull leave to amend. (Petitioner's Appendix, p. 16a.) Hull declined to amend,[3] and he appealed the denial of his motion to remand. The United States Court of Appeals for the Eighth Circuit affirmed the judgment of the district court. (Petitioner's Appendix, pp. 1a-8a.)

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[3] There is no suggestion in this case that Prudential breached a fiduciary duty by providing financial incentives for Dr. Fallon to refuse to precertify medically necessary procedures.

REASONS FOR DENYING THE PETITION FOR CERTIORARI

Hull's Petition for Certiorari advances three arguments, or perhaps suggestions, as to why the Court should issue its writ of *certiorari* in this case: (1) a conflict among the various courts of appeal (Petition for *Certiorari*, pp. 5-7); (2) a failure by the Eighth Circuit to follow the relevant decisions of this Court (Petition for *Certiorari*, pp. 5-7); and (3) the presence of an important federal question that has not been but should be decided by this Court (Petition for *Certiorari*, pp. 8-10). As more fully developed below, none of these arguments or suggestions are well founded.

In his Petition for *Certiorari* Hull expresses the question presented by this case inexactly. A more precise phrasing of the issue is:

> Can a claim that is in fact based upon a denial of benefits under an employee welfare benefit plan be properly removed to federal court, even if the state court pleadings purport not to state a federal claim?

The case thus involves the so-called "well-pleaded complaint" rule announced by this Court in cases such as *Gully v. First National Bank*, 299 U.S. 109 (1936), and *Louisville & Nashville R. Co. v. Mottley*, 211 U.S. 149 (1908), as well as the "complete preemption" exception to that rule recognized by this Court in cases such as *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987), and *Avco Corp. v. Aero Lodge No. 735, Int'l Ass'n of Machinists*, 390 U.S. 557 (1968).

I. No Conflict Exists Among the Circuits.

Hull suggests that the decision of the Eighth Circuit in this case conflicts with two decisions of the Third Circuit, *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3rd Cir.), *cert. denied*, 516 U.S.

1009 (1995), and *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3rd Cir. 1999). This suggestion is incorrect; a review of the differences between the facts in those cases and the facts of this case demonstrates that their holdings are consistent.

Two cases decided by the Seventh Circuit demonstrate the lack of conflict in the decisions of the various circuits dealing with preemption of claims of medical malpractice under ERISA. In *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995), the employee benefit plan was a group insurance contract that paid for medical treatment from designated providers. A designated provider treated the plaintiff. Claiming that the provider was negligent, the plaintiff sued the provider, and also sued the insurer on a *respondeat superior* theory. The Seventh Circuit held that the case was improperly removed from state court, because it did not involve a determination of benefits and therefore was not within the scope of ERISA § 502(a).

A few months later, the same court decided *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996). In *Jass*, a utilization review nurse employed by PruCare determined that inpatient physical therapy was not medically necessary for the plaintiff following knee surgery, and PruCare refused to agree to pay for such therapy. The plaintiff sued both the nurse and PruCare in state court, alleging medical malpractice on the part of the nurse. The nurse filed an uncontradicted affidavit that her only contact with the plaintiff was as a utilization review administrator. The Seventh Circuit distinguished *Rice* and held that the case had been properly removed. *Jass*, unlike *Rice*, involved a denial of benefits, and therefore was within the scope of ERISA § 502(a).

In this case, the district court found that Hull's claim was based on a denial of benefits and therefore was properly removed. Based on the affidavits filed with it, the district court found that Hull's claim was like the claim in *Jass* rather than like the claim

in *Rice:* "Dr. Fallon did not prescribe treatment for Mr. Hull, he merely identified what treatment would be paid for by Mr. Hull's benefit plan."[4] (Petitioner's Appendix, p. 15a.) The Eighth Circuit agreed and affirmed. (Petitioner's Appendix, p. 8a.)

The decision of the Eighth Circuit, however, does not conflict with the decisions of the Third Circuit in *Dukes v. U.S. Healthcare, Inc.*, and *In re U.S. Healthcare, Inc.* There are two significant differences between this case and those cases.

First, in this case the district court had before it uncontroverted affidavits that supplemented and contradicted the facts alleged in the state court pleadings. Those affidavits established that Dr. Fallon was not Hull's treating physician, and that Dr. Fallon did no more than to refuse to agree in advance for PruCare to pay the costs of a thallium stress test. The district court so found, and its findings are not clearly erroneous.

The opinions in the Third Circuit cases do not refer to any explicit factual findings based on affidavits such as those in this case. Apparently, the Third Circuit based its decisions solely on the contents of the state court pleadings. There is little room for departure from the "well-pleaded complaint" rule in such a case.

Second, the Third Circuit did not involve a denial of benefits. They involved no disputes as to what care the participants were entitled to receive. Rather, they involved disputes as to whether the treatment that the participants were undisputedly entitled to receive had been negligently given. Both of those Third Circuit cases fall on the *Rice* side of the line between *Jass* and *Rice*. Indeed, the Third Circuit recognized that line in *In re U.S. Healthcare, Inc.*

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[4] On appeal, Hull did not challenge the factual findings of the district court.

> As an administrator overseeing an ERISA plan, an HMO will have administrative responsibilities over the elements of the plan, including determining eligibility for benefits, calculating those benefits, disbursing them to the participant, monitoring available funds, and keeping records. As we held in *Dukes*, claims that fall within the essence of the administrator's activities in this regard fall within section 502(a)(1)(B) and are completely preempted.

193 F.3d at 162.

There is a clear conceptual distinction between (a) denying benefits on the ground that they are not "medically necessary" (as in *Jass*), and (b) providing substandard medical care (as in *Rice*). As the Third Circuit noted in *In re U.S. Healthcare, Inc.*, it may be difficult to apply this distinction to the facts in some cases, particularly when the same organization has acted both as plan administrator and as a provider of medical services. *Id.* at 162.

This case, however, is not such a case. In this case the district court found as a fact that PruCare did not act as a provider of medical services. Its obligation was to pay for those services that were "medically necessary" and that were provided by others. In this case there is an explicit finding by the district court, based on an uncontroverted affidavit, that Dr. Fallon did no more than refuse to agree in advance that PruCare would pay for a thallium stress test. Even in the Third Circuit this case would have been properly removed.

In short, this case presents no conflicts in the decisions of the various circuits. Those decisions can be readily harmonized by the distinction recognized by the Seventh Circuit in *Jass*.

II. The Eighth Circuit Followed the Relevant Decisions of This Court.

The Eighth Circuit did not "ignore" the recent cases decided by this Court as suggested by Hull. None of the cases cited by Hull (except *Metropolitan Life Insurance Co. v. Taylor,* 481 U.S. 58 (1987)) deal with "complete preemption" under ERISA §502(a). Rather, they are all cases concerned with the scope of the "relate to" clause of ERISA §514(a). Here the Eighth Circuit followed *Metropolitan Life Insurance Co. v. Taylor.* It quite properly did not interpret *California Division of Labor Standards Enforcement v. Dillingham Construction N.A., Inc.,* 519 U.S. 316 (1997), or any of the other cases cited by Hull, as overruling *Metropolitan Life Insurance Co. v. Taylor* or as significantly limiting that decision. This case is simply not one in which the Eighth Circuit "has decided an important federal question in a way that conflicts with the relevant decisions of this Court."

III. There Is No Need for a Decision by this Court.

This is not a case in which a decision by an administrator of an ERISA plan deprived a participant of medically necessary diagnostic procedures. Hull admitted in a sworn affidavit that he could have paid for a thallium stress test even if PruCare did not agree to pay for it. His decision to forego that test did not result from financial compulsion.

Moreover, the distinctions made by the Seventh Circuit in *Rice* and *Jass*, and followed by the Eighth Circuit in this case, are sound. When an administrator of an ERISA plan does no more than refuse to precertify a proposed medical procedure, it has done no more than deny benefits. The participant who believes he is entitled to those benefits has an express cause of action under ERISA §502(a), and that cause of action preempts any state law claims. If, however, an employee benefit plan undertakes itself to provide medical services, it may be held to the

same standard as any other medical practitioner — if it leaves a sponge in a patient's abdomen after surgery, it may be held liable. This distinction provides a sensible accommodation between: (a) the interests of the states in regulating the quality of medical services provided to its citizens; and (b) the federal policies favoring both the protection and encouragement of employee welfare benefit plans and national uniformity in the laws and regulations applicable to such plans. Certainly Hull offers no meaningful arguments against this solution that has been worked out by the lower federal courts.

CONCLUSION

For all the foregoing reasons, the Court should decline to issue its writ of certiorari in this case.

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